

Child and Adolescent Mental Health Division

## Referral Acceptance Form

**Instructions: Boxes 1 through 12 are to be filled out by the FGC Care Coordinator. (CC)**

[1] Client Name:	[2] Client Registration Number:	[3] LOC Requested
[4] Family Guidance Center (FGC)		[5] FGC Care Coordinator
[6] FGC Phone Number	[7] FGC Fax Number	[8] Date Referral Sent to Agency
[9] Name of Provider Agency		[10] Name of Provider Agency Contact Person
[11] Agency Phone Number		[12] Agency Fax Number

**Instructions: Boxes 13 through 18 are to be filled out by the Provider Agency and returned to the FGC within forty-eight (48) hours of receipt of the referral packet.**

[13] Signature of Contact Person	[14] Printed Name of Contact Person
[15] Date Referral Packet Received	[16] Date Referral Accepted
[17] Anticipated Admit Date <b>OR</b>	[18] Date Waitlisted

**PLEASE NOTE:** Should your agency decide to reject this referral for any reason, you must complete this form below and return it to the FGC within the required forty-eight (48) hours from the date of receipt of the referral packet. Both the referral form and the justification must be faxed to the attention of the FGC Chief through the above named CC within forty-eight (48) hours of the date of receipt of the referral packet.

All rejections of referrals will be considered to be in breach of contract requirements unless your agency submits this referral form with a written and signed justification from your Clinical Director.

The FGC Clinical Director will review the justification for the rejection and will contact your agency Clinical Director for a discussion of the issues. The Care Coordinator will inform your agency Intake Coordinator of the outcome of the discussion and any actions to be taken on the part of the FGC and/or your agency.

**REFERRAL REJECTED** ☐

**JUSTIFICATION ATTACHED** ☐

Print Name of Agency Clinical Director

Signature of Agency Clinical Director

Date

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